Illinois Department of Public Aid

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INFORMATIONAL NOTICE

TO: Enrolled Home Health Agencies

RE: Clarification of Prior Approval and Billing Instructions

The department outlined home health billing changes in an informational notice to home health providers dated October 29, 2003. The following information is intended to clarify the prior approval and billing procedures when more than one skilled nursing visit is needed on the same service date.

- No prior approval is needed for one skilled nursing visit per date of service, if the services are provided within 60 days of an inpatient hospital discharge. As indicated in the October 29, 2003 notice, the patient's hospital discharge date (MMDDYYYY format) is required in Box 10 when billing on the DPA 2212.

- If more than one skilled nursing visit per day is needed within 60 days of an inpatient hospital discharge, providers must submit a prior approval request for the total number of skilled nursing visits required for the approval period. Prior approval is required regardless of whether the claim is billed electronically or on paper. If a paper claim is submitted, the discharge date must be omitted from Box 10 on the DPA 2212 and the total number of visits must be shown in the "units" box for each date of service. If billing electronically, the provider must omit the discharge date from the Occurrence Information (HI) of Loop ID 2300 and indicate the number of visits in Loop ID 2400 SV205.

- If a provider has billed for a single skilled nursing visit and it has been adjudicated as payable, but there were actually two skilled nursing visits on that date, the provider may request post-approval for the second visit according to the guidelines identified in Chapter 200, Handbook for Home Health Agencies, topic R-220.3, if the provider had not previously obtained a prior approval for the second visit. If post-approval is granted, then the provider must void the original claim and rebill to correct the total number of visits per date of service. If the provider simply did not bill the second visit, but had obtained prior approval for it, the claim still needs to be voided and rebilled to correct the total number of visits for that date of service.

As a reminder, effective with dates of service on and after April 1, 2004, the department will eliminate local code usage for home health services and require the use of HCPCS codes. It is the responsibility of each provider to ensure that all material related to changes in the department's billing procedures, handbooks, etc. are shared with their software vendor, corporate help desk or information systems area.

Any questions regarding this notice may be directed to the Bureau of Comprehensive Health Services at 217-782-5565.

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Administrator
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